MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02690

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

WITHIN CORPORATE LIMITS

City or town Hagerstown

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Wash. County Hospital

Stay in hospital or inst. (yrs., or mos., or days) 1 day

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Virginia County Berkley

City or town Martinsburg Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME Jack Wayne Albright

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18, 1944

8. AGE:	Years	Months	Days	If less than one day
	0	9	15	hrs. min.

9. Birthplace Martinsburg - Berkley Co. W. Va.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER

12. Name Glenville C. Albright

13. Birthplace Berkley Co., W. Va.

MOTHER

14. Maiden name Isabel D. Naquin

15. Birthplace Honolulu, Hawaii

16. Informant Mrs. Isabell D. Albright

Address Martinsburg, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 5, 1945 (month) (day) (year)

Cemetery or crematory Rose Dale Cemetery

Location Martinsburg, W. Va.

18. Funeral director Howard K. Brown

Address Martinsburg, W. Va.

19. Feb 2 1945 Chas H Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/2 1945, at 1:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/1 1945, to 2/2 1945

and that I last saw h alive on 2/2 1945.

	DURATION
Immediate cause of death: Meningitis - Pneumococcus Type 18	
Due to	
Due to	
Other conditions Septicemia. Pneumococcus pertussis	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J H Bowman M.D
M. D. or other

Address Hagerstown, Md Date signed 2/2/45

MARGIN RESERVED FOR FINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (37)

02091

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH:

County: Washington

City or town: Williamsport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

Lifetime

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Williamsport

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Eliza Monahan Beard

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: William Henry Beard

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 14 1869

8. AGE: Years	Months	Days	If less than one day
75	3	27	..... hrs. ..... min.

9. Birthplace: Williamsport Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER — 12. Name: Peter Light Lemen

FATHER — 13. Birthplace: Berkeley Co., W. Va.

MOTHER — 14. Maiden name: Helen Stake

MOTHER — 15. Birthplace: Williamsport, Md.

16. Informant: Nancy Beard

Address: Williamsport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 12 1945 (month) (day) (year)

Cemetery or crematory: Riverview Cemetery

Location: Williamsport, Maryland

18. Funeral director: Edith V Leaf

Address: #7 Church St. Williamsport, Md.

19. Feb 12 1945 (Date rec'd by registrar) Mrs E Lee McElroy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 10 1945, at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1941, to Feb. 10 1945, and that I last saw h.. alive on Feb. 10 1945

Immediate cause of death	DURATION
Myocarditis Chronic	1941
Due to:	
Due to: Toxic Thyroid	1941
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Williamsport Md Date signed 2/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

02692

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH:
County Washington
City or town Camp Ritchie Hosp Camp Ritchie, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 minutes
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 45 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County ~~Wash~~ Balti
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2116 N. Fulton Ave.*
(If rural, give LOCATION)
2.(a) If veteran, name war no

3. (a) FULL NAME August A. Beyer
3. (b) Social Security Number none

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) February 6, 1906
8. AGE: Years 38 Months 11 Days 26 If less than one day ... hrs. ... min.
9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business Md. State Sanatorium
FATHER 12. Name Charles Beyer
13. Birthplace Unknown
MOTHER 14. Maiden name Augusta — (unknown)
15. Birthplace Unknown
16. Informant Mrs Emma Roemer
Address 2116 N. Fulton Ave, Balto, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 5 1945 (month) (day) (year)
Cemetery or crematory Western Cemetery
Location Baltimore Md
18. Funeral director M. L. Creager & Son
Address Thurmont, Md
19. Feb. 5-6, 1945 (Date rec'd by registrar) Geo. W. Ferguson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2 1945, at 2 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19... and that I last saw h... alive on ... 19...

Immediate cause of death Fractured skull (closed) | DURATION
Due to (Shock)
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results NO
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of Feb. 2 '45
Where did injury occur? Waynesboro (City or town) Franklin (County) Pa. (State)
Injured at home, farm, industry, public place (where) US 16 Highway
Means Auto accident near Wolfe's Inn Injured at work? no
deputy med. exam.
23. SIGNATURE F. R. Hershwells Wash. Co. Md. M. D. or ~~other~~
Address Hagerstown, Md Date signed Feb. 2 1945

*Inf. secured from Informant by phone 3-9-45 ams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13Fe)

02093

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:
409 mitchell Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. Brookline Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME
Cora L. Bloom

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Edward S. Bloom

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 6 - 1868

8. AGE: Years	Months	Days	If less than one day
76	6	19	..... hrs. ..... min.

9. Birthplace Tilghmanton-Wash.Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Jacob Smith
13. Birthplace Tilghmanton Md.

MOTHER
14. Maiden name Margaret Busang
15. Birthplace Tilghmanton Md.

16. Informant Frank L. Bloom
Address Baltimore Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Feb 27 - 1945
(month) (day) (year)

Cemetery or ~~cemetery~~ Rose Hill

Location Hagerstown Md.

18. Funeral director E. M. Suter & Sons

Address Hagerstown Md.

19. Feb 27, 1945
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25, 1945 19..... at 8:00 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 5, 1941 19..... to Feb. 25, 19..... 45 and that I last saw her alive on February 24, 1945 19.....

Immediate cause of death	DURATION
Hypostatic pneumonia	2 days
Due to	
Chronic congestive myocardial failure	4 yrs
Other conditions Chronic nephritis	3 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address 148 W. Washington St. Date signed 2/26/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02094

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: (WITHIN CORPORATE LIMITS) Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1day

Hospital, Institution, or street address where death occurred: Washington County Hospital

How long in hospital or Institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: W. Va. County: Morgan Co

City or town: Cherry Run

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME: Henry Ellis Bowers

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 25, 1944

8. AGE:

Years	Months	Days	If less than one day
0	2	10	..... hrs. ..... min.

8. Birthplace: Cherry Run- Morgan Co.- W. Va. (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER

12. Name: Alva E. Bowers

13. Birthplace: Morgan Co., W. Va.

MOTHER

14. Maiden name: Mazie Marie Rankin

15. Birthplace: Ckerry Run, W. Va.

16. Informant: Alva E. Bowers.

Address: Cherry Run, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 7-45 (month) (day) (year)

Cemetery or crematory: Snyders Chapel Morgan Co.

Location: Sleepy Creek Dist. W. Va.

18. Funeral director: Howard K. Brown

Address: Martinsburg, W. Va.

19. Feb 5. 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/3 1945, at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/3 1945 to 2/3 1945 and that I last saw h alive on 2/3 1945

Immediate cause of death	DURATION
Bronchial Pneumonia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. S. Brown M. D. M. D. or other

Address: Hagerstown, Md. Date signed: 2/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Wells
02095
Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Years
Hospital, institution, or street address where death occurred:
327 West Washington Street.
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 327 West Washington
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Charles William Brown

3.(b) Social Security Number: 705-56-5519

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Sarah
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 2, 1861

8. AGE: Years	Months	Days	If less than one day
83	6	18	..... hrs. ..... min.

9. Birthplace: Hummelstown, Penn.
(Town, county, and state)
10. Usual occupation: Hotel Manger
11. Industry or business: Retired

FATHER
12. Name: Phares Brown
13. Birthplace: Hummelstown, Penn.

MOTHER
14. Maiden name: Mary Rhodes
15. Birthplace: Hummelstown, Penn.

16. Informant: Charles F. Brown
Address: Hagerstown. Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 22/45 (month) (day) (year)
Cemetery or crematory: Oberland Cemetery
Location: Oberland, Penn,

18. Funeral director: Andrew K. Coffman
Address: Hagerstown, Md.

19. Feb 21 1945 (Date rec'd by registrar) Chas. H. Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb, 20 1945 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Chr. myocarditis	10y rs
Due to: acute ventricular fibrillation	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: No
Date of op. .....
Autopsy results: No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: L. Robert Wells M. D. or other
DEPUTY MEDICAL EXAM'R WASH. CO., MD.
Address: Hagerstown, Md. Date signed 2/21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48) K

02695

CERTIFICATE OF DEATH

Reg. Diat. No. 307

1. PLACE OF DEATH:
County: Washington
City or town: Brownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life.
Hospital, Institution, or street address where death occurred: Brownsville Md.
How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Brownsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Brownsville Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: George Thomas Brown.

3. (b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Jane Boteler Brown
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April - 8 - 1869

8. AGE: Years	Months	Days	If less than one day
75	10	3	..... hrs. ..... min.

9. Birthplace: Brownsville Wash. Co. Md.
(Town, county, and state)
10. Usual occupation: Retired Postmaster
11. Industry or business: U. S. Postoffice

FATHER
12. Name: Cornelius Brown
13. Birthplace: Brownsville Wash. Co. Md.

MOTHER
14. Maiden name: Sara Ellen Keaton
15. Birthplace: near Jefferson Fred. Co. Md.

16. Informant: Mrs. Jane Boteler Brown
Address: Brownsville Md.

17. Burial - (Burial, cremation, or removal. Which?) Date thereof: Feb. 13. 1945 (mooth) (day) (year)
Cemetery or crematory: St. Lukes Episcopal Cemetary
Locaiion: Brownsville Md.
18. Funeral director: Wm. J. Bast & Sons
Address: Boonsboro Md.

19. Feb 12 (Date rec'd by registrar) 1945 Cornelius H. Castle, Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 11th 1945, at 2.15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 29" 1943, to Feb. 11" 1945.
and that I last saw him alive on Feb. 10" 1945.

Immediate cause of death	DURATION
Carcinoma of Rectum	1 yr. 1 mon
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: J. Hubert Wade M.D.
M. D. or other
Address: Boonsboro Md. Date signed: 2/12/45.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians - please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (937)

02097

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
510 George Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 510 George Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Catherine C. Cosgrove

3.(b) Social Security Number 219-12-1039

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 30, 1912

8. AGE: Years	Months	Days	If less than one day
32	7	24	..... hrs. ..... min.

9. Birthplace Hagerstown, Wash.Co.Md.
(Town, county, and state)

10. Usual occupation Waitress

11. Industry or business

FATHER 12. Name James Cosgrove
13. Birthplace Lonaconing, Maryland

MOTHER 14. Maiden name Florence Butler
15. Birthplace Bunker Hill, W.Va.

16. Informant Mrs. Florence Cosgrove
Address Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-27-45 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons
Address Hagerstown, Maryland

19. Feb 27 1945 (Date rec'd by registrar) Chas. H. Beard, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24 19 45, at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to ..... 19 .....
and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	DURATION
Chr. myocarditis	
Due to	
Acute coronary occlusion	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury Injured at work?

23. SIGNATURE J. Rubin Wells DEPUTY MEDICAL EXAM. WASH. CO., MD. M. D.
Address Hagerstown, Md. Date signed 2/26/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02098

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or towo limits, write RURAL and give nearest town)
How long in above place of death? 11 years
Hospital, institution, or street address where death occurred:
350 Linganore Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 350 Linganore Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Harry C Croft

3.(b) Social Security Number 716-09-9145

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Nettie Croft
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 27-1869

8. AGE: Years	Months	Days	If less than one day
75	10	14	..... hrs. ..... min.

9. Birthplace St. Thomas-Franklin-Pa
(Town, county, and state)
10. Usual occupation Retired R.R. agent.
11. Industry or business P.R.R.R.
FATHER 12. Name David Croft
FATHER 13. Birthplace St. Thomas Pa
MOTHER 14. Maiden name Ellen Kinard
MOTHER 15. Birthplace St. Thomas. Pa
16. Informant Don K Croft.
Address Hagerstown Md
17. Burial Date thereof Feb 13-1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Cedar Grove
Location Chambersburg Pa
18. Funeral director Scott F. Minnich & Son
Address Hagerstown Md
19. Feb. 12. 1945 Chas H Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1945 at 3.55 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Feb 11 1945
and that I last saw him alive on Feb 11 1945

Immediate cause of death	DURATION
Acute Cardiac Dilatation	
Due to Chronic Myocarditis	
Due to Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or towo) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE M. D. or other
Address Hagerstown, Md Date signed 2/12/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

02699

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington County

City or town Hagerstown Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Washington County Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown Md Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 45 South Potomac Street

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME [redacted] Baby Girl Dailey

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	7 months Fetus

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1945

8. AGE: Years | Months 7 months | Days | If less than one day +1 hrs. 35 min.

9. Birthplace Hagerstown, Wash. County, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name John Henry Dailey

13. Birthplace Charlestown West Virginia

MOTHER 14. Maiden name Violet Gladys Jones

15. Birthplace Long Corning, Md.

16. Informant Violet Gladys Dailey Mother

Address 45 South Potomac St.

17. Cremated (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Wash. Co. Hospital

Location Hagerstown, Md.

16. Funeral director

Address

19. Feb. 13, 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7, 1945, at 10:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from [redacted], to Feb. 7, 1945, and that I last saw h alive on Feb. 7, 1945.

Immediate cause of death	DURATION
Premature	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Carlyn Baptista Jr. M.D. M. D. or other

Address 214 N. Potomac Date signed 2-10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82)

02100

CERTIFICATE OF DEATH

Reg. Dist. No. 304

1. PLACE OF DEATH:
County: Washington
City or town: Hancock R.F.D. 2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hancock R.F.D. 2
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Glenn Clatus Eddy

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan 5 1936

8. AGE: Years	Months	Days	If less than one day
9	1	28	hrs. min.

9. Birthplace: Washington Co. (Town, county, and state)
10. Usual occupation: Infant
11. Industry or business
FATHER 12. Name: Frank B Eddy
13. Birthplace: Washington D.C.
MOTHER 14. Maiden name: Reba E Weller
15. Birthplace: Washington Co.
16. Informant: Frank B Eddy
Address: Hancock Md R.F.D. 2
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 5 1945 (month) (day) (year)
Cemetery or crematory: Rehobeth Cemetery
Location: Near Hancock, Md.
18. Funeral director: Snyder-Rowland
Address: Hancock Md
19. 2/5 (Date rec'd by registrar) 19 45 J P Jenkins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 3 1945 at 10 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 3 1945 to Feb. 3 1945 and that I last saw him alive on Feb. 3 1945

	DURATION
Immediate cause of death: Pneumonia - Type?	10 days -
Due to: Cerebral hemorrhage. Spastic Paraplegia	From Birth From Birth
Due to: (Birth Injury).	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Archie Robert Coburn M. D. Coroner
Address: Clearspring Md Date signed 2/4/45

(Death certificate signed at request of Coroner).

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (742)

02101

CERTIFICATE OF DEATH

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 years

Hospital, Institution, or street address where death occurred: 69 W. Franklin St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wash.

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 69 W. Franklin St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles E. Everly

3.(b) Social Security Number: 212-24-5967

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

8.(b) Name of husband or wife: Annie L. Everly

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 23, 1884

8. AGE:

Years	Months	Days	If less than one day
60	11	30	..... hrs. ..... min.

9. Birthplace: Hagerstown- Wash. Co. Md.
(Town, county, and state)

10. Usual occupation: Restaurant Prop.

11. Industry or business

FATHER
12. Name: Joseph Everly
13. Birthplace: Gettysburg, Pa.

MOTHER
14. Maiden name: Anna M. Kauffman
15. Birthplace: Frederick Co., Md.

16. Informant: Mrs. Annie L. Everly
Address: 69 W. Franklin St.- Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 26 45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Md.

18. Funeral director: Fred W. Kraiss

Address: Hagerstown, Md.

19. Feb 24 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 22, 1945 hr. 45 A. M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	14days
Due to: acute ventricular fibrillation	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work?

23. SIGNATURE: Robert W Reilly M. D. or

Address: Hagerstown, Md. Date signed: 2/23/45

DEPUTY MEDICAL EXAM. WASH. CO., MD.


RECEIVED
FEB 27 1945
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

02102

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Wash. Co. Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Boonsboro
(If outside city or town limits, write RURAL and give nearest town)
Street No.: High St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Infant Faulders

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February - 14 - 1945

8. AGE: Years: — Months: — Days: — If less than one day: 5 hrs. 30 min.

9. Birthplace: Hagerstown Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: David L. Faulders
13. Birthplace: Mt. Lena Wash. Co. Md.

MOTHER
14. Maiden name: Pauline Louise Cunningham
15. Birthplace: Boonsboro Wash. Co. Md.

16. Informant: Charles Cunningham
Address: Boonsboro Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 15. 1945 (month) (day) (year)
Cemetery or crematory: Boonsboro Cemetary
Location: Boonsboro Md.

18. Funeral director: C. W. Bast & Sons
Address: Boonsboro Md.

19. Feb. 14. 1945 (Date rec'd by registrar) Chas. H. Boward, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 14 1945 at 0 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 14 1945, to Feb. 14 1945
and that I last saw him alive on Feb 14 1945

Immediate cause of death	DURATION
Prematurity 7 mos.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Sidney Silverstein M.D.
M. D. or other
Address: Funkstown Md. Date signed: 2/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Beachley

02103

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstwon

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 Years

Hospital, Institution, or street address where death occurred:

117 Winter St.

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 117 Winter St.

(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME Mrs. Mary Madaline Fitzgerald

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife John H.

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) October 1 1869

8. AGE: Years	Months	Days	If less than one day
77	4	23	...hrs. ...min.

9. Birthplace County Mayo Ireland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER 12. Name Michael Battle

FATHER 13. Birthplace County Mayo Ireland

MOTHER 14. Maiden name Mary Larkin

MOTHER 15. Birthplace County Mayo Ireland

16. Informant Miss Mary E. Fitzgerald

Address Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/27/45 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Feb 26 1945 Chas. H. Bowers

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24 1945 at 12.30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 1944 to Feb 24 1945 and that I last saw h... alive on Feb 24 1945

Immediate cause of death	DURATION
Chronic Myocarditis	1 yr.
Due to	
Due to	
Other conditions Uremia & Edema	5 days

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE J. H. Beachley M. D.

Address Hagerstown Md. Date signed Feb 24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

02104

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH:

County: Washington

City or town: Camp Ritchie, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 years

Hospital, institution, or street address where death occurred:
Station Hospital, Camp Ritchie, Md.

How long in hospital or institution? 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Camp Ritchie, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3.(a) FULL NAME: CHARLES (NMI) FRANCESCHINA, Tec 4, ASN 35556395

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 20 January 1907

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
38	0	16	—	—

9. Birthplace: Berlin, Germany
(Town, county, and state)

10. Usual occupation: Soldier

11. Industry or business: U. S. Army

FATHER
12. Name:
13. Birthplace: Unknown

MOTHER
14. Maiden name:
15. Birthplace: Unknown

16. Informant: Camp Ritchie records
Address: Camp Ritchie, Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Feb 6, 1945 (month) (day) (year)
Cemetery or crematory: Transportation
Location: Flushing N. Y.

18. Funeral director: M.L. Creager Son
Address: Thurmont, Md.

19. 6 February 1945 (Date rec'd by registrar)
Geo. W. Ferguson Registrar
local

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 February 1945, at 6:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 January 1945, to 6 February 1945 and that I last saw him alive on 5 February 1945

Immediate cause of death	DURATION
Pulmonary Embolism	
Due to: following emergency appendectomy 10 January 1945.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Acute suppurative appendix

Date of op.: 10 Jan 45

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of: None

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): No

Means of injury: No Injured at work? No

23. SIGNATURE: David Shapiro
DAVID SHAPIRO, Captain, MC
M. D. or other

Address: Sta Hosp, Cp Ritchie, Md. Date signed: 6 Feb 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (512)

CERTIFICATE OF DEATH

02105

Reg. Dist. No. 306

1. PLACE OF DEATH

County: Washington

City or town: Sigettsburg and
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Smithsburg Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. — —
(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME

George. R. Isamand

3.(b) Social Security Number

none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: none

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 7-11-1865

8. AGE:

Years	Months	Days	If less than one day
79	6.	28	— hrs. — min.

9. Birthplace: Near Myersville Frederick md
(Town, county, and state)

10. Usual occupation: Farmer & Grazier

11. Industry or business

FATHER
12. Name: Daniel. Isamand
13. Birthplace: Near Myersville.

MOTHER
14. Maiden name: Catherine. Detrow
15. Birthplace: Near Myersville. Frederick

16. Informant: Mrs Ross Isamand

Address: Smithsburg md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2- 11- 1945 (month) (day) (year)

Cemetery or crematory: Smithsburg

Location: Smithsburg Washington

18. Funeral director: Geo. W. Hoover

Address: Smithsburg md

19. Feb 11 1945 (Date rec'd by registrar) Geo. W. Ferguson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 9 1945 at 7.30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 1 1944 Feb 9 1945 and that I last saw h— alive on Feb 9 1945

	DURATION
Immediate cause of death: Cerebral hemorrhage	4 days
Due to: prostatic Carcinoma	9 Mos
Due to:	
Other conditions: Chronic myocarditis + arteriosclerosis (Include pregnancy within 3 months of death)	10 yrs

Major findings of operations: —

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: G. G. H. Otter M. D. or other

Address: Smithsburg Md Date signed 2/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of age is shown on FILM No. G 94 MAY 11 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

02106

Reg. Dist. No. B 00

1. PLACE OF DEATH:
County: Washington
City or town: Sharpsburg R.f. D.#1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Sharpsburg R.F.D.#1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Theodore Francis Gaylor

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 7 1880

8. AGE: Years	Months	Days	If less than one day
64 -65	4	15	hrs. min.

9. Birthplace: Wash Co Md
(Town, county, and state)

10. Usual occupation: Laborer Farm

11. Industry or business: farm

FATHER
12. Name: Theodore Gaylor
13. Birthplace: Md

MOTHER
14. Maiden name: Josophine Domer
15. Birthplace: Md

16. Informant: Eli Gaylor
Address: Williamsport R.F.D. #1 Md

17. (Burial, cremation, or removal. Which?) Burial
Date thereof (month) (day) (year) Feb 25 1945

Cemetery or crematory: Bakersville Mdm
Location: Bakersville Md

18. Funeral director: Edith V. Leaf
Address: Williamsport Md

19. 2-24 1945
(Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 22 1945, at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Auto coronary occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results: No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Deputy Med Exr
S. Rohrer Wells Washington Co Md
M. D. or other

Address: Hagerstown Md Date signed: 2-23-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92)

02107

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, Institution, or street address where death occurred:
Washington County Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 227 Norway Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James A. Gochenour

3.(b) Social Security Number 719-05-4035

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Nora L. Gochenour

6.(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) November 22, 1884

8. AGE: Years	Months	Days	If less than one day
60	2	13	hrs. min.

9. Birthplace Luray, Virginia
(Town, county, and state)

10. Usual occupation Retird Railroad Brakeman

11. Industry or business N.& W. Railroad

FATHER
12. Name John Gochenour
13. Birthplace Luray, Virginia

MOTHER
14. Maidee name Fannie ------
15. Birthplace Luray, Virginia

16. Informant Mrsl James Gochenour

Address Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-7-45 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. Feb 7. 19 45 Elsie H Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/4/45 19 at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/27 19 45 to 2/4 19 45 and that I last saw h. alive on 2/4/45 19

	DURATION
Immediate cause of death: Congestive Heart Failure	About 1 mo.
Due to: Probably Rheumatic Heart Disease	Unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Calcareous aortic Stenosis; Heart failure

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John A Thomas Baker The. D. M. D. or other

Address 154 W. Washington St - Date signed 2/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02108

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH:

County Washington

City or town Clear Spring
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Clear Spring Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Louise H. Grosh

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

B (b) Name of husband or wife Courtney Grosh, Sr.

B(c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) October 14, 1865

8. AGE: Years	Months	Days	If less than one day
79	3	19	hrs. min.

9. Birthplace Washington County
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Cyrus Dennis

13. Birthplace Washington Co.

MOTHER 14. Maiden name Katherine Giblew

15. Birthplace Carlyle, Pa.

16. Informant Courtney Grosh, Sr.

Address Clear Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 7 1945 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Near Clear Spring, Md.

18. Funeral director Snyder-Rowland

Address Clear Spring Maryland

19. Feb 7 1945 (Date rec'd by registrar) Joseph C. Mulvey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5, 1945, at 10.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1945 to Feb 5, 1945 and that I last saw her alive on Feb. 4, 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	5 days.
Due to Arterio Sclerosis	5 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE David R. Brewer M.D.
M. D. or other

Address Clear Spring Md Date signed 2/5/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15 (T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (58)

CERTIFICATE OF DEATH

02109

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: nagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 days
Hospital, institution, or street address where death occurred: Washington Co. Hospital
How long in hospital or institution? 12days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Pectonville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Issac Henson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: none
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 3 1929

8. AGE: Years: 15 Months: 10 Days: 13 If less than one day: ..... hrs. ..... min.

9. Birthplace: Hagerstown Md (Town, county, and state)

10. Usual occupation: none

11. Industry or business: helped on farm

FATHER — 12. Name: Pride William Henson
13. Birthplace: William sport R.F.D.#1

MOTHER — 14. Maiden name: Carrie Stoner
15. Birthplace: pa

16. Informant: Pride William Henson
Address: Williamsport R,F.D.#1

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 181945 (month) (day) (year)

Cemetery or crematory: Bakersville Cem
Location: Bakersville Md

18. Funeral director: Edith V. Leaf
Address: Williamsport Md.

19. Feb 17 19 45 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 16. 19 45 at 8.50 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 24. 19 45 to Feb 16 19 45 and that I last saw him alive on Feb 15. 19 45

	DURATION
Immediate cause of death: (a) Rheumatic Endocarditis	2 weeks
Due to: Acute Rheumatic Fever	3 weeks
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: David R. Brewer M. D. or other
Address: Clear Spring Md. Date signed 2/17/45

STATE OF MARYLAND—CERTIFICATE OF DEATH

02110

(159)

1. PLACE OF DEATH

County Washington Registration Dist. No. 303

Village or City Boy Town No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Hose Premature Male Birth (6 mos) If U. S. Veteran, specify WAR

(a) Residence: No. Clearspring Md RI St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
M.	W.	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day, and yaar) Feb. 13, 1945

7. AGE	Yeers	Months	Days	If LESS than 1 dey ___ hrs. or 15 min.
—	—	—	—	

OCCUPATION

8. Trade, profession, or particular kind of work dona, as SPINNER, SAWYER, BOOKKEEPER, etc. —

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. —

10. Date deceased last worked at this occupation (month and year) —

11. Total time (yaars) spent in this occupation —

12. BIRTHPLACE (city or town) Clearspring Md.
(State or country) R. I

FATHER

13. NAME Wallace D. Hose

14. BIRTHPLACE (city or town) Washington Co
(State or country) Md

MOTHER

15. MAIDEN NAME Mary Minerva Mills

16. BIRTHPLACE (city or town) S. Franklin Co.
(State or country) Penna.

17. INFORMANT Wallace D. Hose Mary M. Hose
(Address) Clearspring Md

18. BURIAL, CREMATION, OR REMOVAL
Place Memorial Cemetery Date Feb. 13, 1945

19. UNDERTAKER Snyder — Rowland
(Address) Clear Spring Md

20. FILED Feb 13, 1945 Joseph W. Murray
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Feb. (Month) 13 (Day) 1945 (Year)

22. I HEREBY CERTIFY, That I attandad decaasad from Feb. 13 - 1945, to Feb. 13 - 1945

I last saw him alive on Feb. 13 - 1945; death is said to have occurred on the date stated above, at 4:13 A.m.

The **PRINCIPAL CAUSE OF DEATH** and related ceuses of importance were as follows:

	Date of onset
Premature Birth	
6 mos.	

Other **Contributory Causes** of importance:

None Known

Nama of operetion — Date of —

What test confirmed diegnosis? — Wes thare an autopsy?

23. If death was due to external ceuses (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Neture of injury

24. Was diseasa or injury in eny way related to occupation of decaasad?

If so, spacify

(Signed) J. M. Zimmerman M. D.

(Address) Williamsport Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (834)

02111

CERTIFICATE OF DEATH

Reg. Dist. No. 304

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County WASHINGTON
City or town HANCOCK
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: HOME - MAIN ST.
Stay in hospital or inst. (yrs., or mos., or days) —
Stay in this community (yrs., or mos., or days) 70 YRS.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County WASHINGTON
City or town HANCOCK Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. MAIN ST.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME THEODORE PERCIVAL JENKINS

3. (b) Social Security Number —

4. Sex MALE | 5. Color or race WHITE | 6.(a) Single, married, widowed, or divorced MARRIED

6.(b) Name of husband or wife LILLIAN ELIZABETH PERKINS JENKINS 6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) AUGUST 2, 1874

8. AGE: Years 70 | Months 6 | Days 5 | If less than one day ____hrs. ____min.

9. Birthplace HANCOCK, WASH. CO., MARYLAND (Town, county, and state)

10. Usual occupation FUNERAL DIRECTOR

11. Industry or business

FATHER 12. Name MARTIN JENKINS
13. Birthplace WARFORDSBURG, PA.

MOTHER 14. Maiden name ANN CATHERINE ERNST
15. Birthplace CLEAR SPRING, MD.

16. Informant LILLIAN E. JENKINS (WIFE)
Address HANCOCK, MD.

17. BURIAL Date thereof FEB. 10, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory EPISCOPAL CEMETERY
Location HANCOCK, MD.

18. Funeral director A. K. COFFMAN
Address HAGERSTOWN, MD.

19. 8 FEB. 1945 Lillian E. Jenkins
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 1945, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1944 19__, to Feb 7 1945, and that I last saw him alive on Feb 7 1945.

	DURATION
Immediate cause of death: Pulmonary Embolism	instant
Due to Embolism & Clot formed by Cerebral Haemorrhage	—
Due to	
Other conditions	
(Include pregnancy within 3 months of death)	

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE H. E. Fahrney, M.D.
M. D. or other
Address Hancock, Md. Date signed 2/8/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02112

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

17 McKee Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 17 McKee Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lillian M. Jones

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Elmer C. Jones

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): January 19, 1886

8. AGE: Years	Months	Days	If less than one day
59	0	14	...hrs. ...min.

9. Birthplace: Johnson City, W. Va. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Albert Eichelberger

13. Birthplace: Millstone, Maryland

MOTHER — 14. Maiden name: Charlotte Selby

15. Birthplace: Johnson City, W. Va.

16. Informant: Nelson Jones

Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-5-45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. Feb 5 1945 (Date rec'd by registrar) Edward Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 2 1945, at 7.50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 18 1944 to Feb 2 1945 and that I last saw her alive on Feb 2 1945

Immediate cause of death	DURATION
Carcinoma of Sigmoid with Generalized abd.	6 mo.
Due to: metastasis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Inoperable Carcinoma of Sigmoid Date of op. 9/18/44

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: O. H. Bikley M. D. M. D. or other

Address: Hagerstown md Date signed 2/3/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

02113

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 78 years
Hospital, institution, or street address where death occurred:
325 Summit Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 325 Summit Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Samuel E Johnston

3.(b) Social Security Number 220-10-3623

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Rosie B Johnston
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15 1866

8. AGE: Years 78 Months 6 Days 27 If less than one day hrs. min.

9. Birthplace Hagerstown - Washington Md
(Town, county, and state)

10. Usual occupation Mill Worker Retired

11. Industry or business Knitting Mills

FATHER
12. Name Samuel Johnston
13. Birthplace Pa

MOTHER
14. Maiden name Rosie King
15. Birthplace Greencastle Pa

16. Informant Mrs Mary Herrmann
Address Hagerstown Md

17. Burial Date thereof Feb 14 - 1945
(Burial, cremation, or removal. Which?) (mouth) (day) (year)
Cemetery or crematory Rose Hill
Location Hagerstown Md

18. Funeral director Scott F Minnich & Son
Address Hagerstown Md

19. Feb 14 1945 Chas H Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1945, at 5 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 2 - 45 to Feb 12 1945
and that I last saw alive on Feb 10 - 45 1945

Immediate cause of death	DURATION
Chr. Myocarditis	6 yrs
Due to Arterio-sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M. D. or other
Address Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

02114

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 weeks
Hospital, institution, or street address where death occurred: Wash. Co. Hospital
How long in hospital or institution? 4 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Mapleville (If outside city or town limits, write RURAL and give nearest town)
Street No. Mapleville Md. (If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Ellen Nora Keadle
3. (b) Social Security Number: None

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Abraham E. Keadle
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): March 9. 1860

8. AGE:

Years	Months	Days	If less than one day
84	10	22	hrs. min.

9. Birthplace: Mapleville Wash. Co. Md (Town, county, and state)
10. Usual occupation: Housekeeper
11. Industry or business: Own home
FATHER 12. Name: John Shoop
13. Birthplace: Wash. Co. Md
MOTHER 14. Maiden name: Lydia Myers
15. Birthplace: Boonsboro Wash. Co. Md
16. Informant: C. Ned Keadle
Address: Mapleville Md.
17. Burial (Burial, cremation, or removal, Which?) Date thereof: Febry. 4. 1945 (month) (day) (year)
Cemetery or crematory: Boonsboro Cemetery
Location: Boonsboro Md
18. Funeral director: Wm. I. Bast & Son
Address: Boonsboro Md
19. Feb. 3. 1945 (Date rec'd by registrar) Chas. H. Rowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 1 1945, at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 7 1945 to February 1 1945 and that I last saw her alive on February 1 1945

Immediate cause of death	DURATION
Chronic Myocarditis	10 yrs
Due to Senile Dementia	10 yrs
Due to Multiple Bruises from fall	

Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: G. W. Liban M.D. (M.D. or other)
Address: Boonsboro, Md Date signed: Feb. 2, 1945

VS A15

02115

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: 602 George St.

How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown (If outside city or town limits, write RURAL and give nearest town)

Street No. 602 George St. (If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Fred Ellsworth Kershner

3.(b) Social Security Number: 214-09-2213

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Blanche S. Kershner

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 13 1896

8. AGE:

Years	Months	Days	If less than one day
48	7	1	..... hrs. ..... min.

9. Birthplace: Hagerstown Wash. Co. Md. (Town, county, and state)

10. Usual occupation: Maintenance Dept.

11. Industry or business: Fairchild Aircraft Corp.

FATHER 12. Name: Cyrus E. Kershner

13. Birthplace: Virginia

MOTHER 14. Maiden name: Minnie May Dickenhoff

15. Birthplace: Near Clearspring Wash. Co. Md.

16. Informant: Mrs. Blanche S. Kershner

Address: 602 George St. Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 17. 1945 (month) (day) (year)

Cemetery or crematory: Manor Cemetary

Location: Near Tilghmanton Md

18. Funeral director: Wm J. Bast & Sons

Address: Boonsboro Md.

19. Feb. 16. 1945 (Date rec'd by registrar) Elsie H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 14. 1945 at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Gunshot wound through skull	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of 2/14/45

Where did injury occur? Hagerstown (City or town) Wash. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury: Shot self with .32 revolver Injured at work? No

23. SIGNATURE: Roker & Wells DEPUTY MEDICAL EXAM. WASH. CO., MD.

M. D. or other

Address: Hagerstown, Md. Date signed: 2/15/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Beachley

02116

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-(a)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ½ Hour

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? ½ Hour

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

WITHIN CORPORATE LIMITS

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 325 North Cannon Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: John Funk Lehman

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Elsie May

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): July 17 1890

8. AGE: Years	Months	Days	If less than one day
54	6	29	...hrs. ...min.

9. Birthplace: Leitersburg Wash., Co. Md (Town, county, and state)

10. Usual occupation: Telegraph Operator

11. Industry or business: Retired 10 Years

FATHER 12. Name: Claggett Lehman

13. Birthplace: Leitersburg Md.

MOTHER 14. Maiden name: Ida. May Funk

15. Birthplace: Wingerton Pa.

16. Informant: Mrs. Elsie May Lehman

Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/18/45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. Feb 18 1945 (Date rec'd by registrar) Blair H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 16 1945 at 2 P M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Feb 9 1945 to Feb 16 1945 and that I last saw h... alive on Feb 16 1945

Immediate cause of death	DURATION
Coronary Occlusion.	10 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ...

Means of injury: ... Injured at work?

23. SIGNATURE: J. H. Beachley M. D. or other

Address: Hagerstown Md. Date signed: Feb 16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (27)

02117

CERTIFICATE OF DEATH

Reg. Dist. No. 304

1. PLACE OF DEATH:
County: Washington
City or town: Hancock, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Half Hour
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pennsylvania County: Fulton
City or town: Warfordsburg, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: John Frank Lewis

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Georgian Lewis
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): May 11 1873

8. AGE: Years	Months	Days	If less than one day
71	9	16	hrs. min.

9. Birthplace: Fulton County (Town, county, and state)
10. Usual occupation: Farming
11. Industry or business

FATHER
12. Name: John Lewis
13. Birthplace: Not Known

MOTHER
14. Maiden name: Elizabeth Weaver
15. Birthplace: Not Known

16. Informant: Mrs. Georgian Lewis
Address: Warfordsburg, Pa. Rural

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 2 1945 (month) (day) (year)
Cemetery or crematory: Cedar Grove
Location: Near Dott, Pa.

18. Funeral director: Snyder- Rowland
Address: Hancock, Md.

19. 2/28/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2-27 1945 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Cardiac Failure	Seconds
Due to: Hypertension	
Due to: Arteriosclerosis	
Other conditions: Mitral Stenosis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Herbert R. Lofink M. D. or other
Address: Hancock Md. Date signed: 2-28-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02118

Reg. Diat. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 years

Hospital, Institution, or street address where death occurred:

died on way to hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 630 N. Locust

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Wilbur H Martin

3. (b) Social Security Number 214-09-7177

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife Carrie E Martin

6.(c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) March 6 - 1906

8. AGE: Years	Months	Days	If less than one day
38	11	11	..... hrs. ..... min.

9. Birthplace Emmitsburg - Frederick Md (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Superior Dairy Co.

FATHER 12. Name William L. Martin

FATHER 13. Birthplace Emmitsburg Md

MOTHER 14. Maiden name Mary E Hafner

MOTHER 15. Birthplace Greenmount Pa

16. Informant Mrs. Carrie E Martin

Address Hagerstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 20-1945 (month) (day) (year)

Cemetery or crematory Rose Hill

Location Hagerstown Md

18. Funeral director Scott F Minnick Son

Address Hagerstown Md

19. Feb 20 1945 (Date rec'd by registrar) Chas H Boewer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17 1945 at 7.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Pleurisy	10d.
Due to Acute Coronary	
Due to Occlusion	
Other conditions	

(Includa preguancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J Robert Wells M.D. M. D. or other

Address Hagerstown Md Date signed Feb. 18 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

02119

CERTIFICATE OF DEATH

Reg. Dist. No. 316.

1. PLACE OF DEATH:

County Washington

City or town Rural Keedysville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Wash.

City or town Rural Keedysville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Patsy Ann McAfee

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1944

8. AGE: Years	Months	Days	If less than one day
	4	7	hrs. min.

9. Birthplace Wash. County Hospital Hagerstown, Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Elmer Leon McAfee
13. Birthplace Porterstown, Md

MOTHER
14. Maiden name Evelyn H. Miller
15. Birthplace Martinsburg, W. Va.

16. Informant Mr. Elmer L. McAfee

Address Keedysville, Md. R. F. D. #1

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 4 1945 (month) (day) (year)

Cemetery or crematory Tuscarora

Location Martinsburg, W. Va.

18. Funeral director R. I. Earnshaw

Address Keedysville, Md

19. Feb 3 1945 (Date rec'd by registrar) R. A. Beetner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2 1945 at 9:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Acute Bronchial Pneumonia	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. Robert Wells DEPUTY MEDICAL EXAM. WASH. CO., MD. M. D.

Address Hagerstown, Md. Date signed Feb 7 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

02120

Reg. Dist. No. 507 203

1. PLACE OF DEATH:
County Washington
City or town Big Springs Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Big Springs
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME James Fredrick Mckee

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12 1866

8. AGE: Years	Months	Days	If less than one day
78	4	25	hrs. min.

9. Birthplace Indian Springs Md.
(Town, county, and state)
10. Usual occupation laborer Farm
11. Industry or business Farm
FATHER 12. Name James McKee
13. Birthplace Irland
MOTHER 14. Maiden name Rebbeca Cartey
15. Birthplace Md.
16. Informant Mrs Fred McCardel
Address Williamsport Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 10 1945 (month) (day) (year)
Cemetery or crematory BlairsValley Cem
Location BlairsValley Md
18. Funeral director Edith V. Leaf
Address Williamsport Md
19. Feb 10 1945 (Date rec'd by registrar) Mrs E Lee McElroy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1945 at 8 30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Feb 2 1945
and that I last saw h... alive on Feb 2 1945

Immediate cause of death	DURATION
Cancer of Stomach	6 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B Pratler M. D. or other
Address Hagerstown, Md Date signed 7/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

02121

Reg. Diat. No. 300

1. PLACE OF DEATH:

County Washington

City or town Sharpsburg Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Sharpsburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME George William Reed Mongan

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Helen May Pennel

6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) March 8 1878

8. AGE:

Years	Months	Days	If less than one day
66	11	8	....hrs. ....min.

9. Birthplace Sharpsburg Md
(Town, county, and state)

10. Usual occupation Shoe Maker

11. Industry or business shoe Shop

FATHER
12. Name Thomas Mongan
13. Birthplace Va

MOTHER
14. Maiden name Margret Elizebeth Reed
15. Birthplace Va

16. Informant Mrs Ray Benner

Address Sharpsburg Md

17. Burial Date thereof Feb 9 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. View Cem

Location Sharpsburg Md

18. Funeral director Edith V. Leaf

Address Williamsport Md

19 2-8 1945 Earl Boyer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1945, at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1935 19.. to Feb. 6 1945

and that I last saw h.. alive on Feb 6 1945

Immediate cause of death	DURATION
Uremia	1 week
Due to Cardio-Vascular-Renal	7
Due to disease	1
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter H Sheetz M D
M. D. or other

Address Sharpsburg Md Date signed 2/8/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (105)

02122

CERTIFICATE OF DEATH

Reg. Dist. No. 307

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Washington County

City or town: Hagerstown RFD #40 Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 days

Hospital, institution, or street address where death occurred:
Near Hagerstown Md. RFD #40

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown Md. RFD #40
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Hagerstown Md. RFD #40
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME
David Lynn Myers

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Baby

6.(b) Name of husband or wife: Baby

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 13 1945

8. AGE: Years	Months	Days	If less than one day
	1		..... hrs. ..... min.

9. Birthplace: Hagerstown Md. Hospital
(Town, county, and state)

10. Usual occupation: Baby

11. Industry or business

FATHER
12. Name: Wilbur J Myers
13. Birthplace: Williamsport, Md.

MOTHER
14. Maiden name: Kathryn Kendle
15. Birthplace: Waynesbora Pa.

16. Informant: Kathryn Myers (Mother)
Address: Hagerstown Md RFD #40

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 14 1945 (month) (day) (year)

Cemetery or crematory: Rest Haven Cemetery

Location: Hagerstown Md.

18. Funeral director: Edith V Leaf

Address: #7 Church St. Williamsport, Md.

19. Feb 13 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/13/45 1945, at 6 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/11/45 1945 to 2/13/45 1945

and that I last saw alive on 2/13/45 1945

Immediate cause of death	DURATION
Suffocation due to	
Due to edema of (Larynx)	24 hours
Due to (Larynx)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Hagerstown Md Date signed: 2/13/45

MV

02123

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74)

CERTIFICATE OF DEATH

Reg. Diat. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown (WITHIN CORPORATE LIMITS)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
235 Alexander Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown (WITHIN CORPORATE LIMITS)
(If ontside city or town limits, write RURAL and give nearest town)
Street No. 235 Alexander Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Roy E. Nye

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 29, 1932

8. AGE: Years: 12 | Months: 10 | Days: 13 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Hagerstown- Wash. Md.
(Town, county, and state)

10. Usual occupation: School Student

11. Industry or business

FATHER
12. Name: Arthur E. Nye
13. Birthplace: Hagerstown, Md.

MOTHER
14. Maiden name: Gladys
15. Birthplace: Hagerstown, Md.

16. Informant: Arthur E. Nye
Address: 235 Alexander St.- Hagerstow , Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 14 45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown, Md.

18. Funeral director: Fred W. Kraiss
Address: Hagerstown, Md.

19. Feb 14, 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 11, 1945 4:10 A. M. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 15 1944 to Feb 11 1945
and that I last saw him alive on Feb 10 1945

Immediate cause of death	DURATION
acute Lymphatic Leukaemia	(2)
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: V. Victor D. Miller M. D. or other
Address: 131 W. WASHINGTON. ST. Date signed: 2/12/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02124

Reg. Diat. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years.
Hospital, institution, or street address where death occurred:
923 Maryland ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wash.
WITHIN CORPORATE LIMITS
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 923 Maryland ave
(If rural, give LOCATION)
2.(a) If veteran, name war none

3.(a) FULL NAME William C. Oden

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Anna O. Oden
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 16, 1876

8. AGE: Years	Months	Days	If less than one day
68	10	20	..... hrs. ..... min.

9. Birthplace Wolfsville, Fred. Md (Town, county, and state)
10. Usual occupation Sheet Metal Worker
11. Industry or business Victor Products Corp
FATHER 12. Name Nathaniel E. Oden
FATHER 13. Birthplace Near Knoxville Md
MOTHER 14. Maiden name Elizabeth Richardson
MOTHER 15. Birthplace Baltimore Md.
16. Informant Mrs Vernon Nichols
Address Hagerstown Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 9, 1943 (month) (day) (year)
Cemetery or crematory Rose Hill
Location Hagerstown Md
18. Funeral director Lisk & Minnich Don
Address Hagerstown Md.
19. Feb. 7. 1945 Chas H Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1945 at 7:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1942 to Feb. 5 1945
and that I last saw h[illegible] alive on Feb 3 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to Hypertension;	
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B Frantz M. D. or other
Address Hagerstown Md Date signed 2/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Oswald

02125

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 week
Hospital, institution, or street address where death occurred: Washington County Hospital
How long in hospital or institution? one week

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md   County: Washington
City or town: Cavetown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Allen H. Oswald

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: white
6.(a) Single, married, widowed, or divorced: widowed
6.(b) Name of husband or wife: Emma S. Bachtell
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Sept. 7, 1857

8. AGE:

Years	Months	Days	If less than one day
87	4	25	... hrs. ... min.

9. Birthplace: Washington Co. Md
(Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business:

FATHER
12. Name: Benjamin Oswald
13. Birthplace: Washington Co. Md

MOTHER
14. Maiden name: Sophia Bell
15. Birthplace: Washington Co. Md

16. Informant: Miss Irene Oswald
Address: Cavetown, Md.

17. Burial (Burial, cremation, or removal. Which?)
Date thereof: 2/5/45 (month) (day) (year)
Cemetery or crematory: Smithsburg Cemetery
Location: Smithsburg, Md.
18. Funeral director: Walter Y. Grove
Address: 27 S. Church St. Waynesboro, Pa.
19. Feb 3. 1945 (Date rec'd by registrar) Registrar: Chas. H. Bowers

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 2, 1945, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 24, 1945, to Feb 2, 1945,
and that I last saw him alive on Feb 2, 1945

	DURATION
Immediate cause of death: Pulmonary Embolism	5 mts
Due to: intertrochanteric fracture of femur (left)	5 days
Due to: Accidental fall January 27th 1945 At his residence	
Other conditions: Arteriosclerosis + chronic myocarditis	20 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: G. A. K. Oiler, M. D. or other
Address: Smithsburg   Date signed: 2/2/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

02127

CERTIFICATE OF DEATH

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 yrs
Hospital, institution, or street address where death occurred:
59 Harmon ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 59 Harmon ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Nannie P. Puller

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	Married

6.(b) Name of husband or wife William Puller
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
74	Feb		hrs. min.

9. Birthplace Martinsburg W. Va. (Town, county, and state)
10. Usual occupation House Work
11. Industry or business

FATHER
12. Name William Puller
13. Birthplace Shepherdstown Md.

MOTHER
14. Maiden name
15. Birthplace Martinsburg W. Va.

16. Informant Harry E. Myers
Address 59 Harmon ave

17. (Burial, cremation, removal, other) Date thereof Feb 8, 1945 (month) (day) (year)
Cemetery or crematory Bellevue Home
Location Hagerstown

18. Funeral director William H. Bowers
Address 291 Frederick St.

19. Feb 6 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3, 1945 at 4 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
acute cerebral hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L V Rohrer M. D.
DEPUTY MEDICAL EXAM. WASH. CO., MD.
Address Hagerstown, Md. Date signed 2/6/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02126

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, institution, or street address where death occurred:
801 Virginia Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 801 Virginia Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles D. Reel

3.(b) Social Security Number: 214-09-9070

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Helen M. Reel
6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): April 23, 1886

8. AGE: Years	Months	Days	If less than one day
58	10	30	....hrs. ....min.

9. Birthplace: Sharpsburg, Wash.Co.Md. (Town, county, and state)
10. Usual occupation: Tool Crib
11. Industry or business: Fairchild Aircraft

FATHER
12. Name: Thomas H. Reel
13. Birthplace: Sharpsburg, Wash.Co.Md.

MOTHER
14. Maiden name: Mary Grice
15. Birthplace: Sharpsburg, Wash.Co.Md.

16. Informant: Mrs. Helen M. Reel
Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-25-45 (month) (day) (year)
Cemetery or crematory: Mountain View Cemetery
Location: Sharpsburg, Maryland

18. Funeral director: C. M. Suter & Sons
Address: Hagerstown, Maryland

19. Feb 24 1945 (Date rec'd by registrar) Elwyn H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 22 1945 at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19.... to ....19....
and that I last saw h....alive on ....19....

Immediate cause of death	DURATION
Chr. Myocarditis	1yr
Due to: acute ventricular dilatation	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op....
Autopsy results: NO
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. Robert Lowell DEPUTY MEDICAL EXAM WASH. CO., MD.
Address: Hagerstown Md M. D. Date signed: Feb 23 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Wells
02128

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 21

CERTIFICATE OF DEATH

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 Years
Hospital, institution, or street address where death occurred:
221 East Baltimore St.
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 221 East Baltimore St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Charles Emory Renner

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Susan
6.(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): April 30 1866

8. AGE: Years	Months	Days	If less than one day
78	9	12	....hrs. ....min.

9. Birthplace: Hagerstown Wash. co. Md.
(Town, county, and state)
10. Usual occupation: Foreman Danzer Lumber Co.
11. Industry or business: Retired
FATHER 12. Name: Elias Renner
13. Birthplace: Myersville Md.
MOTHER 14. Maiden name: Matilda Ambrose
15. Birthplace: Beaver creek Md.
16. Informant: Mrs. Leona Smith
Address: Hagerstown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/14/45 (month) (day) (year)
Cemetery or crematory: Rest Haven Cemetery
Location: Hagerstown Md.
18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.
19. Feb 14 1945 (Date rec'd by registrar) C. Kast Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 12 1945 19.... at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1938 to Feb. 12'45 19.... and that I last saw him alive on Feb. 11'45 19....

Immediate cause of death	DURATION
Generalized vascular arteriosclerosis	10yrs
Due to: Chr. myocarditis	4yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: No Date of op. ....
Autopsy results: ND
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ND Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury Injured at work?

23. SIGNATURE: J. Robert Wells M.D.
M.D.
Address: Hagerstown, Md. Date signed 2/12/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (72)

02129

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH:
County: Washington
City or town: Smithsburg Md # 2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Washington
City or town: Smithsburg #2
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Norman Ray Reynolds

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Sept 29 1937

8. AGE:

Years	Months	Days	If less than one day
7	4	25	hrs. min.

9. Birthplace: Edgemont Md (Town, county, and state)
10. Usual occupation: Ni School
11. Industry or business:
FATHER 12. Name: Elder B Reynolds
13. Birthplace: Ringgold Md
MOTHER 14. Maiden name: Eva C Miller
15. Birthplace: Edgemont Md
16. Informant: Mr Elder B Reynolds
Address: Smithsburg Md # 2
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2 26 1945 (month) (day) (year)
Cemetery or crematory: Smithsburg Cemetery
Location: Smithsburg Md
18. Funeral director: Walter G Grove
Address: Waynesboro Pa
19. Feb 24 1945 (Date rec'd by registrar) Geo W. Ferguson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 24 1945 at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 16 1945 to Feb 24 1945 and that I last saw h— alive on Feb 24 1945

Immediate cause of death	DURATION
Acute Meg Intis	3 days
Due to Sub acute Bacterial	10 days
Due to Ens of car dis	
Due to Rheum Fever	7 mos
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: G G Hooker M. D. or Other
Address: Smithsburg Date signed 2/24/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

02130

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Security, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Security, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Ralph Joseph Rigley

3.(b) Social Security Number: 216-07-2789

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Martha Rigley

6.(c) If alive, give age: 28 years

7. Birth date of deceased (mo., day, yr.): October 17, 1914

8. AGE: Years	Months	Days	If less than one day
30	3	23	hrs. min.

9. Birthplace: Lonaconing, Maryland
(Town, county, and state)

10. Usual occupation: Burner

11. Industry or business

FATHER
12. Name: Albert Rigley
13. Birthplace: Nottingham, England

MOTHER
14. Maiden name: Laura Morris
15. Birthplace: Frostburg, Maryland

16. Informant: Mrs. Ralph Rigley

Address: Security, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2-12-45 (month) (day) (year)

Cemetery or crematory: St. Marys Cemetery

Location: Lonaconing, Maryland

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. Feb. 10. 1945 (Date rec'd by registrar) Chas H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 9, 1945, at 4:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 21, 1944, to Feb. 10, 1945 and that I last saw him alive on Feb. 8, 1945

Immediate cause of death	DURATION
Tuberculous Pulmonary	1940
" Pneumothorax	5 months
Due to Tuberculous Enteritis	6 weeks
" Peritonitis	2 weeks
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: X Date of: X

Where did injury occur? X (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W Howard Geeg M. D., or other

Address: Hagerstown, Md Date signed: Feb. 11, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02131

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 wks
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Frederick
City or town Rural Myersville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war World War I

3.(a) FULL NAME Oscar Calvin Schroyer

3.(b) Social Security Number 216-07-8485

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Eva M. Schroyer
6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Oct. 26. 1893

8. AGE: Years	Months	Days	If less than one day
51	3	17	...hrs. ...min.

9. Birthplace Myersville, Frederick Co., Md.
(Town, county, and state)
10. Usual occupation Fairchild Aircraft Employee
11. Industry or business

FATHER
12. Name Calvin Schroyer
13. Birthplace Myersville, Md.

MOTHER
14. Maiden name Etta Schroyer
15. Birthplace Myersville, Md.

16. Informant Eva Schroyer
Address Myersville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-15-45 (month) (day) (year)
Cemetery or crematory U. B. Cemetery
Location Myersville, Md.

18. Funeral director Biddhill Co.
Address Middletown, Md.

19. Feb 15 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13" 1945, at F-15" M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 7" 1944, to Feb. 13" 1945
and that I last saw him alive on Feb. 12" 1945

Immediate cause of death	DURATION
Chronic Myocarditis	4 mos.
Due to	
Due to	
Other conditions Acute	4 mos.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Hubert Mackey M.D.
M. D. or other
Address Braunbeck, Md. Date signed 2/13/45.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

02132

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington County

City or town Hagerstown Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 weeks

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Fulton Ave. Williamsport, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Fulton Ave. Williamsport, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ralph Mumma Siler

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Nellie Banzhoff deceased 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 23 1892

8. AGE: Years	Months	Days	If less than one day
53	1	3	hrs. min.

9. Birthplace Harrisburg, Pa. (Town, county, and state)

10. Usual occupation Leather finisher at

11. Industry or business Williamsport, Tannery

FATHER 12. Name Edward Siler

13. Birthplace Pa.

MOTHER 14. Maiden name Last name Mumma

15. Birthplace Pa.

18. Informant Earnie Banzhoff

Address Williamsport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 28 1945 (month) (day) (year)

Cemetery or crematory Riverview Cemetery

Location Williamsport, Maryland

18. Funeral director Edith V Leaf

Address #7 Church St. Williamsport, Md.

19. Feb 27 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/26/45 19 at 4PM.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/26/44 19 to 2/26/45 19

and that I last saw h[illegible]ive on 2/26/45 19

Immediate cause of death	DURATION
Cerebral Apoplexy	Immediate
Due to: Malignant Hypertension	3 mo.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ralph F. Young M. D. or other

Address Williamsport, Md. Date signed 3/2/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

02133 Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: 407 S. Potomac Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 407 S. Potomac Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Louise Snavely

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Harry S. Snavely
6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): February 7, 1894

8. AGE: Years	Months	Days	If less than one day
51	0	16	hrs. min.

9. Birthplace: Hagerstown, Wash. Co. Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: B. F. Poffenberger
13. Birthplace: Hagerstown, Wash. Co. Md.

MOTHER
14. Maiden name: Anna Reynold
15. Birthplace: Hagerstown, Wash. Co. Md.

16. Informant: Harry S. Snavely
Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-25-45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown, Maryland
18. Funeral director: C. M. Suter & Sons
Address: Hagerstown, Maryland

19. Feb 24 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 23 1945 at 7.20 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 23 1945, to Feb. 23 1945 and that I last saw h.er alive on Feb. 23 1945

Immediate cause of death	DURATION
Coronary Occlusion	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. D. Campbell M. D. or other
Address: Hagerstown Md. Date signed 2/23/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Porterfield

02134

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 58 Years
Hospital, institution, or street address where death occurred:
1828 Virginia Ave
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1828 Virginia Ave
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Otho Scott Snook

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Katherine

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 28 1857

8. AGE: Years	Months	Days	If less than one day
87	9	27	...hrs. ...min.

9. Birthplace Boonsboro Washington Co. Md.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business Retired

FATHER
12. Name Jacob Snook
13. Birthplace Frederick Md.

MOTHER
14. Maiden name Sylvia Keyser
15. Birthplace Frederick Md.

16. Informant Norman J. Snook
Address Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/27/45 (month) (day) (year)
Cemetery or crematory Mausoleum Rose Hill Cemetery
Location Hagerstown Md.

18. Funeral director Andrew K. Coffman
Address Hagerstown Md.

19 Feb 26 1945 Chas. H. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 1945 19.. at 5.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1943 to Feb 25 1945 and that I last saw him alive on Feb 24 1945

Immediate cause of death	DURATION
Cerebral Sclerosis	2
Due to Arteriosclerosis	7
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE H. L. Porterfield M.D.
M. D. or other
Address 136 W Washington Date signed 2/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

02135

CERTIFICATE OF DEATH

Reg. Dist. No. 304

1. PLACE OF DEATH:
County: Washington Co.
City or town: Rural Big Pool Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months
Hospital, institution, or street address where death occurred: —
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Penna. County: Fulton
City or town: Rural, Crystal Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Dacie L Slade

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Clinton Slade
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Feb. 28 1864

8. AGE: Years: 80 | Months: 11 | Days: 11 | If less than one day: hrs. min.

9. Birthplace: Greenwood Pa R.D. (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: —

FATHER
12. Name: Wesley Clark
13. Birthplace: Bedford Co. Penna

MOTHER
14. Maiden name: Garlick
15. Birthplace: Bedford Co. Penna

18. Informant: Ezra L. Shaw
Address: Big Pool Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 11 1945 (month) (day) (year)
Cemetery or crematory: Mt. Pleasant
Location: Greenwood Pa R.D.

18. Funeral director: J. Wilmer Sipes
Address: Harrisonville Pa

19. Feb. 9 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 8 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1944, to Feb 8 1945
and that I last saw h[illegible] alive on Feb 4 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: F M Shafer MD (M. D. or other)
Address: Hancock Md. Date signed: 2/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

02136

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown R7 No 2 (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 1 year

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Mayland County Washington

City or town Hagerstown R7 No 2 Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Shirley Jeanett Spade

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

B (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 8 1944

8. AGE:

Years	Months	Days	If less than one day
1	1	17	hrs. min.

9. Birthplace Broadfording Wash Co. (Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER

12. Name Alexander Spade

13. Birthplace Fulton Co Pa

MOTHER

14. Maiden name Edith M. Hull

15. Birthplace Washington Co.

16. Informant Mr Alexander Spade

Address Hagerstown Md R7 No 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 27 1945 (month) (day) (year)

Cemetery or ~~crematory~~ Dunkard

Location Broadfording

18. Funeral director Snyder-Routland

Address

19. Feb 26 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1945, at 7:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 23, 1945 to Feb 25. 1945 and that I last saw h alive on Feb 24. 1945

Immediate cause of death Broncho Pneumonia — DURATION 2 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE David R. Brewer M. D. or other

Address Clear Spring Md Date signed 2/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Dr Kneisley

02137 Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

Chewsville Pike

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Chewsville Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Chewsville & Cavetown Road

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Webster L. Spessard

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Effie

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Febuary 7, 1871

8. AGE: Years	Months	Days	If less than one day
74	6	19	....hrs. ....min.

9. Birthplace: Chewsville Wash. Co. Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Retired

FATHER 12. Name: David R. Spessard

FATHER 13. Birthplace: Chewsville Maryland

MOTHER 14. Maiden name: Ella Line

MOTHER 15. Birthplace: Keedysville, Maryland

16. Informant: Mrs Effie Spessard

Address: Chewsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 28, 1945 (month) (day) (year)

Cemetery or crematory: Green Hill Cemetery

Location: Waynesboro, Penn.

18. Funeral director: Andrew K. Coffman

Address:

19. Feb 26 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Febuary 26 1945 at 7A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 28, 1944 to Feb. 26, 1945

and that I last saw him alive on February 26, 1945

Immediate cause of death	DURATION
Coronary occlusion	15 min
Due to: Coronary sclerosis	Indef.
Due to:	
Other conditions: Chronic myocarditis	Indef.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: B. B. Kneisley M. D. M. D. or other

Address: 148 W. Washington St. Date signed 2/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Victor Miller

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)(a)

CERTIFICATE OF DEATH

02138

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstwon
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 Years
Hospital, Institution, or street address where death occurred:
230 Alexander St.
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 230 Alexander st.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Mrs. Laura Savilla Sprankle

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Augustus
6.(c) If alive, give age -

7. Birth date of deceased (mo., day, yr.) May 2 1861

8. AGE: Years	Months	Days	If less than one day
83	9	20	hrs. min.

9. Birthplace Maugansville Wash. Co. Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own Home

FATHER
12. Name Jacob Shipp
13. Birthplace Waynesboro Pa.

MOTHER
14. Maiden name Caroline Kelly
15. Birthplace Lancaster Pa.

18. Informant Clyde H. Sprankle
Address Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/25/45 (month) (day) (year)
Cemetery or crematory Dunkard Cemetery
Location Broadfording Md.
19. Funeral director Andrew K. Coffman
Address Hagerstown Md.

19 Feb 23 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22 1945 at 7 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 15 1944 to Feb 22 1945 and that I last saw h[illegible] alive on 2/18 - 1945

Immediate cause of death	DURATION
Chronic Endocarditis	2
arterio-Sclerosis	
Due to Chronic Nephritis.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Victor D. Miller M. D.
DR. VICTOR D. MILLER,
Address 131 W. WASHINGTON, ST HAGERSTOWN, MD. Date signed 2/27 1945

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47(C)

CERTIFICATE OF DEATH

02139

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Washington Co. Hospital
Stay in hospital or inst. (yrs., or mos., or days) 5 days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Penna County Franklin
City or town Greencastle Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 17 So. Washington
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR √

3. (a) FULL NAME Nelson Stine

3. (b) Social Security Number 204-03-3622

4. Sex Male | 5. Color or race White | 6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Nina Mayhugh

6(c) If alive, give age 57-3 years

7. Birth date of deceased (mo., day, yr.) May 8th 1888

8. AGE: Years 56 | Months 9 | Days 9 | If less than one day ____ hrs. ____ min.

9. Birthplace Franklin Co. Pa (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Machine Shop

FATHER 12. Name James Stine

13. Birthplace Pennsylvania

MOTHER 14. Maiden name Clercy Stine

15. Birthplace Pennsylvania

16. Informant Nina Stine

Address Greencastle, Penna

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/20/45 (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Greencastle Pa

18. Funeral director Mrs. David Martin

Address Greencastle, Pa

19. Feb 19 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/17 1945, at 7:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/1 1945, to 2/17 1945, and that I last saw him alive on 2/16 1945.

	DURATION
Immediate cause of death Bronchogenic Carcinoma	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy Bronchogenic Carcinoma

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. L. Brewer M. D.

Address Greencastle Pa Date signed 2/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186a

CERTIFICATE OF DEATH

Dr. Novenstene

02140

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Weeks

Hospital, institution, or street address where death occurred:

Washington Counth Hospital

How long in hospital or institution? 6 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown R # 3

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Beaver Creek Road

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Charles Elmer Summers

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Alice

6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): July 9 1869

8. AGE: Years	Months	Days	If less than one day
75	7	3	..... hrs. ..... min.

9. Birthplace: Wolfesville Fred. Co. Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: -

FATHER

12. Name: Jacob Summers

13. Birthplace: Wolfesville Md.

MOTHER

14. Maiden name: Ellen Hoover

15. Birthplace: Wolfesville Md.

16. Informant: Mrs. Alice Summers

Address: Hagerstown Md. R # 3

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/15/45 (month) (day) (year)

Cemetery or crematory: Rest Haven Cemetery

Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstwon Md.

19. Feb 14. 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 12 1945 19..... at 3.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from see 28 19 44 to February 12 19 45 and that I last saw h.. alive on Feb. 12 19 45

	DURATION
Immediate cause of death: Cerebral Thrombosis	Jan 23-1945
Due to: arterio-Sclerosis Cerebral	
Due to:	
Other condition: Fracture Lft Femur	see 28-1944

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: see 28-1944

Where did injury occur? Hagerstown #3 (City or town) Wash. (County) Md. (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Fell on ice Injured at work? No

23. SIGNATURE: Sidney Novenstern M.D. M. D. or other

Address: Funkstown Md Date signed: 2/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

02141

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: (WITHIN CORPORATE LIMITS) Hagerstown (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: Wash. Co. Hospital

How long in hospital or institution? 10 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: (WITHIN CORPORATE LIMITS) Hagerstown (If outside city or town limits, write RURAL and give nearest town)

Street No. 528 Salem Ave. (If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Lester Herman Titlow

3.(b) Social Security Number: 717-07-9291

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Hazel Titlow

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): April 17, 1894

8. AGE: Years	Months	Days	If less than one day
50	9	17	...hrs. ...min.

9. Birthplace: Hagerstown Wash. Co. Md. (Town, county, and state)

10. Usual occupation: Engine Inspector

11. Industry or business: Pennsylvania Railroad

FATHER — 12. Name: David Titlow

FATHER — 13. Birthplace: Baltimore Md

MOTHER — 14. Maiden name: Mary Jane Snyder

MOTHER — 15. Birthplace: Greencastle Penna.

18. Informant: Mrs. Hazel Titlow

Address: 528 Salem Ave. Hagerstown Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Feb. 9. 1945 (month) (day) (year)

Cemetery or crematory: Rest Haven Cemetery

Location: Hagerstown Md.

18. Funeral director: Wm J. Bert & Sons

Address: Boonsboro Md

19. Feb. 7. 1945 (Date rec'd by registrar) C. Kath H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 4, 1945 at 2P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ...19..., to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Extensive 3rd degree burns	
Due to: of body and extremities	
Due to: Shock	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 2/4/45

Where did injury occur? Hagerstown (City or town) Wash. (County) Md. (State)

Injured at home, farm, industry, public place (where?): Pennsylvania Railroad Roundhouse

Means of injury: Burned Injured at work? Yes

23. SIGNATURE: L. Robey Wells DEPUTY MEDICAL EXAM. WASH. CO., MD. M. D.

Address: Hagerstown, Md. Date signed: 2/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15 (T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (33a)

Dr. Kohler 02142

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washingyon
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 Years
Hospital, institution, or street address where death occurred:
652 North Mulberry St.
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Wash ngton
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 652 North Mulberry St
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Mrs. Clara Rowe Troxell

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife William
6.(c) If alive, give age —
7. Birth date of deceased (mo., day, yr.) February 19 1855

8. AGE: Years	Months	Days	If less than one day
89	11	29	...hrs. ...min.

9. Birthplace Roxbury Wash. Co. Md. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own Home
FATHER 12. Name Abraham Rowe
13. Birthplace Shiloh Md.
MOTHER 14. Maiden name Ann Elizabeth Gallagher
15. Birthplace Shiloh Md.
16. Informant Mrs. Sherry C. Ridenour
Address Hagerstown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/12/45 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Hagerstown Md.
18. Funeral director Andrew K. Coffman
Address Hagerstown Md.
19. Feb 12 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 1945 19..., at 10 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 16 1944 to Feb 9 1945
and that I last saw h... alive on Feb 9 1945
Immediate cause of death Cerebral Hemorrhage — DURATION 3 mos
Due to Cerebro Sclerosis — 4 yrs
Due to ...
Other conditions ...
(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE G. C. Kohler M. D.
Address Hagerstown Md. Date signed 2/10/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

02143

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

867 Dewey Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 867 Dewey Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sarah Ann Wagner

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife James A. Wagner

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) November 2, 1867

8. AGE: Years	Months	Days	If less than one day
77	3	9	..... hrs. ..... min.

9. Birthplace Emmittsburg, Maryland (Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business

FATHER 12. Name William Dorsey

13. Birthplace Emmittsburg, Maryland

MOTHER 14. Maiden name Margaret C. Martin

15. Birthplace Emmittsburg, Maryland

16. Informant Mrs. Warren Smith

Address Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-14-45 (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. Feb 13, 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11, 1945, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1925 to Aug 1944

and that I last saw h... alive on Aug 44, 1944

Immediate cause of death	DURATION
Pectoris Angina	1 min
Due to Hypertension and Arteriosclerosis	6 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. McAllan Brown M. D. or other

Address 164 W. Wash'n Date signed 2-12-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94(a)

CERTIFICATE OF DEATH

02144

Reg. Diat. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown R D 5

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 years

Hospital, Institution, or street address where death occurred:

Leitersburg Pike

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown R D 5

(If outside city or town limits, write RURAL and give nearest town)

Street No. Leitersburg Pike

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Leonard F. Werking

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife Cora E Werking

6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Feb 15 1878

8. AGE: Years 67 | Months 0 | Days 9 | If less than one day ..... hrs. ..... min.

9. Birthplace Creagerstown Frederick Md (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Self

FATHER 12. Name John W Werking

13. Birthplace Near Walkersville Md

MOTHER 14. Maiden name Mary Garing

15. Birthplace Near Walkersville Md

16. Informant Albert N Werking

Address Hagerstown Md RD 5

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 27-1945 (month) (day) (year)

Cemetery or crematory Lutheran

Location Funkstown Md

18. Funeral director Scott F Minnich Son

Address Hagerstown Md

19. Feb 27 1945 (Date rec'd by registrar) Chas H Boyer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1945 at 9.15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 24, 1945, to Feb. 24, 1945

and that I last saw him alive on January 16, 1945

	DURATION
Immediate cause of death: Coronary occlusion	Instant death
Due to: Coronary arteriosclerosis	7 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations No operations Date of op.

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R A Beel M. D. or other

Address Hagerstown Md Date signed 2/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02145

Reg. Diat. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years

Hospital, institution, or street address where death occurred:

543 Dewey Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 543 Dewey Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Richard J Williams

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Augusta A Williams

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 15 1855

8. AGE:

Years	Months	Days	If less than one day
89	2	5	..... hrs. ..... min.

9. Birthplace Sykesville-Howard-Md (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Retired

FATHER 12. Name John W Williams

13. Birthplace England

MOTHER 14. Maiden name Mary Jones

15. Birthplace England

16. Informant Mr. W. H. Zippy

Address Hagerstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 23-1945 (month) (day) (year)

Cemetery or crematory St. James

Location West Friendship Md

18. Funeral director Lee F Minnick & Son

Address Hagerstown Md

19. Feb 21 1945 (Date rec'd by registrar) Chas H Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20 1945 at 5:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-20-45 19.. to 2-20-45 19..

and that I last saw h in alive on 2-20-45 19..

Immediate cause of death	DURATION
Congestive Heart Failure	1 hour
Due to	
Hypertensive Heart Disease	10 Years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Earl Young M D M. D. or other

Address 148 W Potomac St Hagerstown Md Date signed 2/21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Binkley

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

02146

Reg. Diat. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Week

Hospital, Institution, or street address where death occurred:
Washington County Hospital

How long in hospital or institution? 1 Week

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 307 Summit Ave
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Harvey William Zeigler

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Maude

6.(c) If alive, give age: 85 years

7. Birth date of deceased (mo., day, yr.): October 3 1855

8. AGE: Years	Months	Days	If less than one day
89	4	19	....hrs. ....min.

9. Birthplace: Leitersburg Wash. Co. Md
(Town, county, and state)

10. Usual occupation: R.R.Express

11. Industry or business: Retired

FATHER
12. Name: Charles Zeigler
13. Birthplace: Leitersburg Md.

MOTHER
14. Maiden name: Margaret Barnhart
15. Birthplace: Leitersburg Md.

16. Informant: Harvey P. Zeigler
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/24/45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. Feb 23 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 21 1945 at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 30 1945 to Feb 21 1945 and that I last saw him alive on Feb 21 1945

	DURATION
Immediate cause of death: Gangrene, Both feet	7 days
Due to: Arterio Sclerosis	10 yrs
Due to:	
Other conditions: Chr. Nephritis	2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury: .... Injured at work?

23. SIGNATURE: O.H.Binkley M.D.
M. D. or other

Address: Hagerstown, Md. Date signed 2/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15